Senate Budget & Fiscal Review

Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, & Veterans Affairs

Senator Wesley Chesbro, Chair
Senator Gilbert Cedillo
Senator Tom McClintock
Senator Bruce McPherson
Senator Deborah Ortiz

March 3, 2003
2:30 PM or Upon Adjournment of Session
Room 4203

(Diane Van Maren, Consultant)

Item	*Description*
2400	**Department of Managed Health Care – Selected Issues**
4120	**Emergency Medical Services Authority – Selected Issues**
4260	**Department of Health Services—Healthy Families related items (only)**
4280	**Managed Risk Medical Insurance Board (MRMIB)—Selected Issues**

I. 2400 Department of Managed Care & Office of Patient Advocate

A. BACKGROUND

Purpose and Description of the Department

The purpose of the Department of Managed Health Care (DMHC) is to protect the public through administration and enforcement of laws regulating health care plans. The administration of these laws involves a variety of activities including licensing, examination, and responding to public inquiries and complaints. The program enforces its laws through administrative and civil action. **Specifically, the DMHC licenses health care plans, conducts routine financial and medical surveys, and operates a consumer services toll-free complaint line.**

The DMHC has three advisory boards--the Advisory Committee on Managed Care, the Clinical Advisory Board, and the Financial Standards Solvency Board. In addition, the Office of the Patient Advocate located within the DMC will help ensure that the needs of managed care consumers are heard and met.

The DMHC is funded completely with special funds—the Managed Care Fund. Most of the funds deposited into the Managed Care Fund are derived from Health Care Plans paying annual assessments as outlined in Health and Safety Code, Section 1356.

Overall Budget of the Department

With respect to the Mid-Year Reductions, the Legislature adopted the Administration's two proposals. First, $1 million in administrative penalties collected pursuant to a ruling by the Office of Administrative Hearings (case number N2000070472) was transferred to the General Fund to assist in the fiscal shortfall. Second, a reduction of $558,000 (Managed Care Fund) and 14 positions were taken pursuant to Control Section 31.60 regarding vacant positions.

The budget for 2003-04 proposes total expenditures of $34.5 million (Managed Care Fund) and 314 positions for the DMHC, which includes $2.1 million for the Office of Patient Advocate. This reflects a *net* increase of $1.9 million (Managed Care Fund) over 2002-03. The Legislative Analyst's Office has raised no issues regarding this department.

Summary of Expenditures (dollars in thousands)	2002-03	2003-04	$ Change	% Change
Health Care Service Plans	$30,615	$32,409	$1,794	5.9
Office of Patient Advocate	2,018	2,135	117	5.8
Total, Health Plan Program (Managed Care Fund)	**$32,633**	**$34,544**	**$1,911**	**5.9**

B. ITEMS FOR DISCUSSION—Department of Managed Health Care (DMHC)

1. Proposed Salary Savings Adjustment

Background: When the DMHC was established as of July 1, 2000, a total of 190 positions were transferred from the Department of Corporations, and an additional 145 new positions were established to address the comprehensive reforms regarding health care and health maintenance organizations.

Many of the new positions which were originally funded at the first salary step were typically being filled with employees eligible for higher steps. As such, the salary savings level has been running at 12.4 percent, when it should be operating at about 7 percent.

According to the DOF, "salary savings" reflect personnel cost savings resulting from vacancies and downward reclassifications as a result of turnover of employees. The amount of budgeted salary savings is an estimate generally based on past experience.

Governor's Proposed Budget: The DMHC **is requesting an increase of $834,000 (Managed Care Fund) to reduce the department's salary savings level from 12 percent to 7 percent.** This will allow existing vacant positions to be filled. **Without the requested funding, about 39 positions in the budget year would be required to be kept vacant.**

Department Summary
As of February 1, 2003

			12 Percent Level		7 Percent Level	
		Vacancies		Available		Available
Office	Proposed	as of 2/1/03	Required	to Fill	Required	to Fill
Admin Services	54.0	7.0	6.8	0.2	4.4	2.6
Director's Office	22.0	5.0	2.8	2.2	1.8	3.2
Enforcement	26.0	4.0	3.3	0.7	2.1	1.9
Hlth Plan Oversight	81.0	15.0	10.2	4.8	6.6	8.4
HMO Help Center	70.0	6.0	8.8	-2.8	5.7	0.3
Legal Services	28.0	1.0	3.5	-2.5	2.3	-1.3
Tech & Innovation	20.0	1.0	2.5	-1.5	1.6	-0.6
TOTAL, DMHC	**301.0**	**39.0**	**37.9**	**1.1**	**24.4**	**14.6**
Patient Advocate	13.0	1.0	1.6	-0.6	1.1	-0.1
TOTAL	**314.0**	**40.0**	**39.5**	**0.5**	**25.5**	**14.5**

The Legislative Analyst's Office has raised no issues with this proposal.

Subcommittee Request and Questions: The Subcommittee has requested the **DMHC to respond to the following questions:**

- **1.** Please provide a brief overview of your request.

Budget Issue: Does the Subcommittee want to adopt the request as proposed?

II. 4120 Emergency Medical Services Authority (EMSA)

A. BACKGROUND

Purpose and Description of the Department

The overall responsibilities and goals of the Emergency Medical Services Authority (EMSA) are to **(1)** assess statewide needs, effectiveness, and coordination of emergency medical service systems; **(2)** review and approve local emergency medical service plans; **(3)** coordinate medical and hospital disaster preparedness and response; **(4)** establish standards for the education, training and licensing of specified emergency medical care personnel; **(5)** establish standards for designating and monitoring poison control centers; **(6)** license paramedics and conduct disciplinary investigations as necessary; **(7)** develop standards for pediatric first aid and CPR training programs for child care providers; and **(8)** develop standards for emergency medical dispatcher training for the "911" emergency telephone system.

Overall Budget of the Department

With respect to the Mid-Year Reduction, the Legislature adopted the Administration's proposal to reduce the EMSA by $77,000 (General Fund) to reflect savings by shifting a position to special fund support and reducing out-of-state travel. **However, the Administration's proposal to transfer the EMSA to the Department of Health Services for savings of $342,000 ($132,000 General Fund) was not adopted.**

The Administration's budget for 2003-04 assumes total funding of $14.9 million ($3.9 million General Fund) within the DHS, to reflect the proposed transfer. This level of funding reflects a reduction of about $28.2 million (total funds) compared to 2002-03. **Most of this reduction is due to the elimination of $20 million (General Fund) for trauma care centers and the end of the first phase for the federal bioterrorism grant.**

B. ITEMS RECOMMENDED FOR CONSENT *(Items 1 to 4—Through Page 8)*

1. Paramedic Licensure and Enforcement Program

Background: According to the EMSA, since 1994 the workload for both the Paramedic Licensure Program and Enforcement Program has increased because there has been an increase in the number of paramedics (from 7,600 in 1994 to 11,900 in 2002) and the number of federal and state mandates for licensing agencies. In addition, the EMSA must ensure that misconduct by paramedics is appropriately disciplined. However, the number of staff who review and process the applications for licensure has decreased from three positions to 2.5 positions.

The EMSA contends that in order to ensure there are valid and competent paramedics available to render competent prehospital emergency medical care, they must have the resources necessary to be able to **(1)** review paramedic renewal applications to ensure paramedics have met the

continuing education requirements to renew paramedic licenses before their expiration dates, and **(2)** process new paramedic license applications to fill the current shortage of 1,000 paramedics statewide.

Governor's Proposed Budget: The budget proposes **an increase of $100,000 (EMS Personnel Fund) to (1)** contract with the Attorney General's Office and the Office of Administrative Law ($70,000 total) to conduct activities related to paramedic prosecutions, and **(2)** provide for temporary help expenses related to licensing activities ($30,000).

Subcommittee Staff Recommendation: Subcommittee staff recommends approval of the request. No issues have been raised by constituency groups or the LAO and the proposal seems reasonable based on workload.

2. Paramedic Investigations

Background: The EMSA's Enforcement Unit is responsible for investigating alleged violations of the Health and Safety Code and recommending disciplinary action against the licenses of EMT-Ps (paramedics). There are approximately 12,000 paramedics in the state with that number increasing substantially each year.

According to the EMSA, the Enforcement Unit has experienced an increase in cases resulting in a substantial backlog. In fact, the unit had to implement a policy for written prioritization of cases wherein only Level I (high immediate risk to the public) cases are immediately assigned to investigators. Level 2 (probably risk to the public) and Level 3 (low risk) cases are assigned only as resources become available.

Based upon current projections, the average caseload for an EMSA investigator is 100 cases annually. As a comparison, the California Medical Board has a caseload of about 25 cases.

Staffing levels in the Enforcement Unit have not increased since 1997.

Governor's Proposed Budget: The budget **proposes an increase of $59,000 (EMS Personnel Fund) to fund an Investigator Assistant position in the Enforcement Unit.**

The Investigator Assistant would be responsible for providing assistance to the Enforcement Unit by obtaining documents, serving subpoenas, and performing other related duties. Specifically much of their time would be spend conducting criminal background investigations to determine suitability for a paramedic license (this is presently being conducted by a part-time Student Assistant).

Subcommittee Staff Recommendation: Subcommittee staff recommends approval of the request. No issues have been raised by constituency groups or the LAO and the proposal seems reasonable based upon workload.

3. California Emergency Medical Services Information System (CEMSIS)

Background: In 1997, California's EMS community embarked upon an aggressive and unprecedented statewide EMS planning process. Through this process, a comprehensive assessment was completed and included 90 recommendations for improvement, fifteen of which directly impacted the collection and use of prehospital data. It was agreed that a common data collection and information management system be developed and implemented. A feasibility study report (FSR) for implementation of the project was approved and initial funding was provided in 2000 (federal fund grant from the Office of Traffic Safety).

The objective of the CEMSIS project is to create a statewide database of EMS-based patient information and to then link that data whenever possible.

Governor's Proposed Budget: The budget proposes an increase of $85,000 (federal funds) to operate and house the CEMSIS at the Health and Human Services Data Center (HHSDC). The EMSA notes that the CEMSIS will contain data that is confidential and will be relied upon for departmental business operations. As such, state policy requires that it be housed at the HHSDC.

The amount needed to operate the CEMSIS was calculated by the HHSDC staff based upon resource requirements identified by the vendor chosen by competitive bid to implement the system, and volume estimates supplied by EMSA project staff.

Subcommittee Staff Recommendation: Subcommittee staff recommends approval of the request. No issues have been raised by constituency groups or the LAO and the proposal seems reasonable.

4. Emergency Medical Services to Children (EMSC)—Constituency Request

Background: Historically, EMS systems have primarily focused on the assessment, care and treatment of adults and have not addressed the special needs of children. Even though considerable work has been conducted over the past few years, the EMSA notes that there is still not consistent application of standardized care in California for emergency medical services to children. Children have unique problems and needs associated with acute injury and illness, and suffer from different types of injuries and illnesses than adults. As a result, children require different types of diagnostic procedures, medication, and support techniques.

Through a small federal grant the EMSA began to develop an **Emergency Medical Services for Children (EMSC) Model.** From the beginning, the major goal of the project has been development and implementation of EMSC within local or regional EMS agencies. EMSC represents a linked "continuum of care", intended to integrate community pediatric emergency and critical care delivered in many various settings by many different care providers.

The continuum includes both clinical and operational components. The clinical components are: prevention, prehospital personnel education, pediatric basic life support and advanced life support equipment, prehospital treatment protocols, emergency department

organization and equipment, pediatrics within general trauma centers, interfacility consultation and transfer, pediatric critical care centers, pediatric trauma centers, and pediatric rehabilitation. **The operational components are:** system planing, implementation and management, and information management.

The EMSA organized 14 different multidisciplinary subcommittees to address and describe, through guidelines or recommendations, each of the different EMSC clinical and operational components.

AB 3483, Statutes of 1996, required the EMS Authority to:

- Provide advice and technical assistance to local EMS agencies on the integration of emergency medical services to children into their EMS system;
- Monitor the implementation of the system at the local level;
- Establish a Technical Advisory Committee; and
- Work with the DHS and other agencies to craft standards and policies for the delivery of emergency and critical care services to children.

Report to the Legislature on EMS for Children (August 2000): As required by the enabling legislation, the EMSA published a comprehensive report on the status of EMS for children activities. **Key products included:**

- Established an **EMSC Technical Advisory Committee** (TAC) comprised of pediatric experts;
- Developed **a 5-year plan for California** which outlines specific EMSC needs along with action steps necessary to achieve the goals;
- Developed an **EMSC Model** that assisted in the development of standards and key products that make up the Model;
- Provided technical assistance and consultation visits to local EMS agencies for help in implementing the EMSC Model into their EMS system; and
- Convened three EMSC conferences to promote the implementation of EMSC.

Governor's Proposed Budget: The budget proposes **an increase of $80,000 (federal funds) to contract for a Emergency Medical Services Coordinator to incorporate the standards and protocols developed by the Technical Advisory Committee** (TAC) into state regulations and make strategic improvements to the EMS for Children Program.

Subcommittee Staff Recommendation: Subcommittee staff recommends approval of the request. No issues have been raised by constituency groups or the LAO and the proposal seems reasonable.

C. ITEMS FOR DISCUSSION

1. Transfer of the EMSA to the Department of Health Services

Background and Governor's Proposed Budget: The EMSA was created as a separate entity from the Department of Health Services in 1980, primarily due to dissatisfaction among emergency medical service constituency groups with the state's emergency medical service system.

In an effort to reduce state government, the Administration has proposed to consolidate the EMSA with the Department of Health Services. **The budget assumes savings of $342,438 ($138,440 General Fund, $128,198 federal funds, $62,607 EMS Personnel Fund, and $13,193 EMS Training Program Approval Fund) from this proposal.**

Specifically, the savings would be achieved by eliminating five positions--the Chief Deputy, Health Program Manager III, and three clerical support. In addition, it assumes that the Director of the EMSA is downgraded to a Career Executive Assistant (CEA) III level for savings of almost $13,000 (total funds). In addition, the Administration proposes trailer bill language which would achieve the proposed consolidation.

Subcommittee Hearing of January 15th and Constituency Comment: In the Subcommittee's January 15th hearing, numerous constituency groups testified against the consolidation. **Among many comments presented, it was noted that the EMSA:**

- Needs to remain independent in order to effectively manage and coordinate the multiple functions for which it is responsible and meet the needs of constituencies;
- Has conducted a comprehensive planning process for the Future Vision of California's EMS System which now needs to proceed with implementation;
- Has a long history of successfully working with a wide representation of constituencies on emergency preparedness and response;
- Needs to maintain the Commission on EMS as a regulatory body, not change to an advisory body as would occur under the proposed consolidation; and
- Is recognized as being expert at establishing medical standards and regulations for local EMS systems, including a hospital standards component.

The Subcommittee did not receive any testimony in support of the consolidation, nor has it received any correspondence in support of it.

Subcommittee Staff Alternative—Adopt Budget Bill Language: **In lieu of the consolidation**, it is suggested for the Subcommittee **to (1) reduce the EMSA state support item by $138,000 (General Fund),** the same amount as attributable to the proposed consolidation, **(2) adopt Budget Bill Language, and (3) restore the approximate $ 204,000 in federal and special funds** that would not be transferred over to the DHS. The suggested language is as follows:

Item 4120-001-0001 Provision 1.

It is the Legislature's intent for any reduction taken in this item to be obtained from state support only and not local assistance. This may include efficiencies and savings obtained from personnel expenditures, operating expenditures or equipment.

Subcommittee Request: The Subcommittee has requested **the EMSA to briefly explain the consolidation proposal.**

Budget Issue: Does the **Subcommittee want to adopt the budget proposal, the Subcommittee staff alternative or another option in order to achieve General Fund savings?**

2. California Poison Control System—Shift Funding to 911 Surcharge

Background--Overall: **The California Poison Control System (CPCS) is a major source of poison information**, **treatment and referral assistance to public and health professionals through their emergency hotlines (24-hour, 7 days a week).** It should be noted that the calls not only pertain to the ingestion of potentially toxic household products**, but also allergic reactions to products such as hair products, over-the-counter medications, the use of home cleaners,** and even the potential poisoning of pets/animals.

The staff also provides **a 24-hour interpreter service, Hazmat, public health surveillance and state of the art information references. They are currently preparing information and procedures to prepare for biological, chemical and nuclear terrorism threats to California.**

It should be noted that a portion of the CPCS activities consists of receiving and responding to transferred 911 calls.

California saves over $55 million annually in health care-related costs as a result of poison control consultations.

Background—Key Statistics: At the request of the Subcommittee, the CPCS has provided the following statistics regarding their services:

- Managed more than 367,000 poison calls in 2002
- 51 percent of poisonings involved children under 5 years of age.
- CPCS saves $7 for every $1 of cost
- 61,000 emergency department/physician office visits were averted by poison control consultants.

Current Year Funding: The CPCS has expenditures of about $9 million or so annually. Funding is obtained from a variety of sources, including in-kind support from the University of California at San Francisco, the City and County of San Francisco, some industry contracts, $1.6 million in federal HRSA funds, **$3.6 million in General Fund support from the EMSA and about $3.3 million in federal supplemental funds obtained from the California Medical Assistance Commission (CMAC).**

The Budget Act of 2002 reduced General Fund support by $400,000.

It should be noted that some Medi-Cal supplemental federal funds which had been previously made available to the CPCS will no longer be provided by CMAC. This is due to changes in the state's Selective Provider Hospital Contract Medicaid Waiver which was just approved by the federal government a few weeks ago. In essence, additional funds to be made available under the Waiver need to be provided for other uses, most notably disproportionate share hospitals, the Los Angeles County Health System, Children's Hospitals and graduate medical education assistance.

Governor's Proposed Budget: **The Administration proposes to use $3.6 million from the 911 Account to backfill for General Fund support for the California Poison Control System (CPCS).**

These additional 911 revenues would be obtained by increasing the 911 surcharge rate from 0.75 percent to 1 percent of intrastate phone charges (placed on monthly phone bills) to be effective as of November 1, 2003. It is estimated that $50 million would result from this increase and that various state activities, including the CPCS, would be funded with this adjustment.

Subcommittee Request and Questions: The Subcommittee has requested the Administration to respond to the following questions:

- **1. Please explain why the 911 Account makes sense to use for this purpose.**
- **2. Is it likely that supplemental federal funds previously obtained from CMAC will be available in 2003-04 for this purpose? Could the current-year CMAC funding be further reduced or placed in jeopardy?**
- **3. From a public policy perspective, what may occur if funding is not provided for the CPCS?**

Legislative Analyst's Office Comment: The LAO contends that the Administration's proposed use of 911 surcharge funds is not consistent with current law for the 911 Account is to pay for equipment-related expenses, not other activities. Specifically, Section 41136 of Revenue and Taxation Code allows government agencies and telephone companies to receive funding to maintain 911 database and network functions, and install computer aided dispatch systems and software.

In addition, the LAO believes that use of the 911 Account for the CPCS would not be equitable because other "Public Safety Answering Points" such as homeless shelters, are not included in the Administration's proposal.

Subcommittee Staff Recommendation: Due to the General Fund shortfall, it is recommended to adopt the Administration's proposal to fund CPCS with $3.6 million in 911 Account funds. Without these funds, it is unlikely that the CPCS could be maintained.

Further, though other Public Safety Answering Points would not be eligible for 911 Account funding under the Administration's proposal, the CPCS should be viewed differently due to the often urgent medical nature of potential poisonings and the overall level of health care savings--

including potential emergency transportation—that often result from the services provided by the CPCS.

Budget Issue: Does the **Subcommittee want to adopt the Administration's proposal** to adjust the 911 surcharge?

3. Hospital Bioterrorism Preparedness Program—Federal HRSA Funds

Background—Overall Summary: The Emergency Supplemental Appropriations for Recovery & Response to Terrorist Attacks on the US Act (Public Law 107-117 of 2002), among many other things, **provided California with about $100 million** overall in increased federal support to address both local and state concerns regarding the threat of bioterrorism.

Specifically, this level of funding includes the following:

- $60.8 million from the federal Centers for Disease Control (CDC) to the DHS;
- $24.6 million from the CDC to Los Angeles County (including Long Beach City and Pasadena City). These funds are to be directly provided to the county upon approval by the federal government of the county's application.
- **$9.9 million from the federal Health Resources and Services Administration (HRSA) to the DHS and transferred to the EMSA;**
- $3.7 million from HRSA to Los Angeles County (directly); and
- $2.2 million from the federal Department of Health and Human Services provided directly from DHHS to certain metropolitan areas.

The funds provided to the state were obtained by submitting two comprehensive applications-- one to HRSA and one to the CDC. These applications and funding were discussed in a comprehensive manner through the budget deliberations which crafted the Budget Act of 2002.

Background—HRSA Hospital Funds: To obtain the federal HRSA funds, California submitted a comprehensive application (with the Governor's endorsement) on April 15, 2002. **The federal HRSA funds are to be expended to develop and implement regional plans to improve the capacity of hospitals,** their emergency departments, outpatient centers, emergency medical service systems and other collaborating healthcare entities for responding to situations requiring mass immunization, treatment, isolation and quarantine in the event of infectious disease outbreaks or bioterrorism.

Though the DHS will be receiving these funds directly from HRSA, they intend to have the Emergency Medical Services Authority (EMSA) utilize the funds for further developing and implementing emergency medical systems (as is the EMSA's responsibility).

According to the EMSA, there are **three "critical benchmarks"** that are contained in the state's HRSA grant application. **These include: (1)** staffing and medical direction for the program; **(2)** creation of a Hospital Bioterrorism Preparedness Planning Committee, and **(3)** coordination

among the three grant programs (i.e., CDC, HRSA and federal DHHS) to standardize protocols and minimize redundancy.

Budget Act of 2002: The Budget Act of 2002 **appropriated about $8.5 million (federal funds) for local assistance** to develop and implement bioterrorism response planning in California **and $597,000 (federal funds) for state support (four limited-term positions through June 30, 2003).**

Update on EMSA Activities: The EMSA states that the **Hospital Bioterrorism Preparedness Planning Committee,** consisting of 46 representatives from hospitals, clinics, emergency medical services, public health and others, **has established priorities for funding as follows: (1)** Communications, **(2)** medications, **(3)** personal protective equipment, **(4)** decontamination facilities, **(5)** surge capacity, **(6)** smallpox, **(7)** standardized training programs for healthcare providers, **(8)** clinic focus—enhancement of general and terrorism emergency management planning and preparedness, and **(9)** statewide standardized training program. **These priorities are consistent with and meet the HRSA guidelines as described in the grant notice, and have been forwarded to the EMSA for final consideration.**

The EMSA states that they are "on target" to meet the deadlines as outlined in the state's application and that implementation will begin in mid-March and be fully implemented during 2003-04.

Governor's Proposed Budget: The Administration **proposes to expend a total of $594,000 (federal funds) to fund four limited-term positions** and related costs (total of $450,000) **and an interdepartmental contract—primarily for a Medical Director** (total of $144,000)--to complete implementation of the bioterrorism response plan, and perform follow-up contract audits and compliance reviews. This proposal basically extends for one more year the proposal contained in the Budget Act of 2002.

Specifically, the four limited-term positions (extend to June 30, 2004) include: a Hospital Bioterrorism Preparedness Program Coordinator, an Associate Health Program Advisor, an Associate Governmental Program Analyst, and an Office Technician. In addition, the EMSA will contract with a Medical Director with expertise in emergency medicine and bioterrorism planning, to provide medical direction of the program.

The EMSA notes that the terms of the HRSA grant require the appointment of adequate staff to support the program and allow for program administration costs to be included in the budget.

Subcommittee Request and Questions: The Subcommittee **requested the EMSA to provide a *brief* update** regarding the implementation of the Hospital Bioterrorism Preparedness Program and to respond to the following questions:

- **1.** Please briefly describe your proposal and why the positions are needed for one more year. (What key milestones need to be completed?)

III. 4280 Managed Risk Medical Insurance Board (MRMIB)

A. BACKGROUND

Purpose and Description of the Board

The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health coverage through private health plans to certain groups without health insurance. **The MRMIB administers the (1) Healthy Families Program, (2) Major Risk Medical Insurance Program, and (3) Access for Infants and Mothers (AIM).**

Overall Budget of the Board

The budget proposes total expenditures of $972.4 million ($92.3 million General Fund, $511.6 million Federal Trust Fund, $220 million Tobacco Settlement Fund, and $148.5 million in other funds) for all programs administered by the Managed Risk Medical Insurance Board. Of this amount, $7.1 million is for state operations and $965.3 million is for local assistance.

The budget proposes key changes to the Healthy Families Program and the Access for Infants and Mothers Program.

Summary of Expenditures (dollars in thousands)	2002-03	2003-04	$ Change	% Change
Program Source				
Major Risk Medical Insurance (including state support)	$41,220	$40,082	($1,138)	(2.8)
Access for Infants & Mother (including state support)	$96,461	$117,488	$21,027	21.8
Healthy Families Program (including state support)	$706,673	$814,780	$108,107	15.3
Totals, Program Source	**$844,354**	**$972,350**	**$127,996**	**15.2**
General Fund	**$31,285**	**$92,310**	**$61,025**	**195**
Federal Funds	**$445,867**	**$511,585**	**$65,718**	**14.7**
Tobacco Settlement Fund	**$234,752**	**$220,000**	**($14,752)**	**(6.3)**
Other Funds	**$132,450**	**$148,455**	**$16,005**	**12**
Total Funds	**$844,354**	**$972,350**	**$127,996**	**15.2**

B. ITEMS RECOMMENDED FOR CONSENT *(Items 1 Through 2—To Page 16)*

1. Eliminate the Sunset Date for the Healthy Families Program

Background: Through the federal Balanced Budget Act of 1997, President Clinton proposed and Congress adopted, a comprehensive children's health initiative-- **the State's Children's Health Insurance Program (SCHIP)**-- to expand health coverage to eligible low-income children.

In response to this opportunity, the Legislature and Governor advanced the Healthy Families Program (HFP) through a package of legislation, including **(1)** AB 1126/97 (Figueroa and Villaraigosa), **(2)** SB 903/97 (Lee and Maddy), **(3)** AB 1572/97 (Villaraigosa and Gallegos), and **(4)** AB 217/97 (Figueroa).

The Healthy Families Program provides health, dental and vision coverage through managed care arrangements to uninsured children in families with incomes up to 250 percent of the federal poverty level. Families pay a monthly premium and copayments as applicable. The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

California's HFP legislation established **a sunset date of January 1, 2004** for the program to provide an opportunity for future reconsideration of the program's structure and design (because it was new).

The federal SCHIP legislation allows for 10 years of funding beginning in federal fiscal year 1998 through federal fiscal year 2007. This legislation also designated the total funding level for each federal fiscal year and specified the allocation formula to the states.

Governor's Proposed Budget: The Administration **is proposing to repeal Section 12693.99 of the Insurance Code which contains the sunset clause (January 1, 2004)** for the Healthy Families Program (HFP).

Subcommittee Staff Recommendation: Subcommittee staff recommends adoption of the proposal. The Legislative Analyst's Office has raised no issues.

2. Administrative Transfers

Background and Governor's Proposed Budget: Like most small Boards, MRMIB has traditionally out-sourced their administrative functions to a larger state department—the Office of Statewide Health Planning and Development (OSHPD). This was done through a series of inter-agency agreements between the two entities for the past 11 years.

At this time, MRMIB seeks to transition this arrangement by increasing MRMIB staff by two positions to conduct activities related to business services, personnel and accounting, and deleting 3.5 positions at OSHPD which had previously performed this work.

The budget proposes to provide two positions—Personnel Specialist I and Business Services Officer I—at the MRMIB to perform the specified administrative functions. No increase in funding is being requested. As such, the proposal does not result in a net increase to the state in positions or support cost.

Subcommittee Staff Recommendation: Subcommittee staff recommends adoption of the proposal. The Legislative Analyst's Office has raised no issues.

C. ITEMS FOR DISCUSSION

1. MRMIB Administrative Support Reductions

Background: The budget for 2003-04 provides the MRMIB with $7 million ($1.7 million General Fund, $3.3 million federal funds, $1.9 million in Proposition 99 Funds and $99,000 in Reimbursements) to fund about 68 positions to conduct administrative support functions associated with the Healthy Families Program, the Access for Infants and Mothers (AIM) Program and the Major Risk Medical Insurance Program.

***Mid-Year Reduction Proposal*:** The Legislature adopted the Administration's Mid-Year Reduction to reduce the MRMIB support item for 2002-03 by $191,000 ($66,000 General Fund).

Governor's Proposed Budget: The budget proposes to reduce administrative costs by $360,000 ($125,000 General Fund), or 5 percent of their overall expenditures. (Seven percent of their General Fund support.) Of this amount, **(1)** $299,000 or 83 percent is being reduced from external contracts, **(2)** $35,000 is from out-of-state and in-state travel, and **(3)** $26,000 is from various operating expenses, including training, data processing and equipment.

Subcommittee Request and Questions: The Subcommittee has requested the MRMIB to respond to the following questions:

- **1.** Please briefly explain the proposal.

Budget Issue: Does the **Subcommittee want to adopt the proposal?**

2. Proposed Consolidation of the Access for Infants and Mothers (AIM) Program (See *HAND OUT* for trailer bill language)

Background—Existing Program: The Access for Infants and Mothers (AIM) Program **provides health insurance coverage to uninsured women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age.**

Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level, including the application of Medi-Cal income deductions. (Generally, women below 200 percent of poverty are eligible for Medi-Cal.) **Subscribers must be no more than 30 weeks pregnant and pay a subscriber contribution equal to 2 percent of the family's annual income (average of $790) plus $100 for the infant's second year of coverage, or only $50 if the infant's vaccinations are current.** AIM is not an entitlement program. The level of available funding determines the enrollment capacity.

Currently, AIM offers coverage through **9 contracted health plans.**

AIM Expenditures Increasing Significantly: Over the past several years, costs and enrollment for AIM have exceeded budgeted levels. As a result, the MRMIB has submitted several requests to the Legislature for additional funds in order to avoid having to cap enrollment levels. At the same time, the primary funding source for AIM (Proposition 99 Funds—Physician Account, Hospital Services Account, and Unallocated Account) has continued to decline.

Specifically, expenditures for AIM have increased substantially over the past two years—by 76 percent—as noted in the chart below.

Summary of Expenditures	2001-02 Actual	2002-03 Estimated	2003-04 Proposed
Fund Source: (Dollars in Millions)			
Perinatal Insurance (Proposition 99 Funds)	$62.5	$83.2	$97.3
General Fund	1.5	0.3	7.1
Tobacco Settlement	--	4.3	--
Federal Funds	2.9	8.6	13.1
TOTALS	**$66.9**	**$96.4**	**$117.5**
Percent change		**44%**	**22%** **76% (2 yrs)**

Most of this increased cost is attributable to increased caseload, as well as increasing HMO rates to provide this type of coverage. **The MRMIB notes that a separate program, such as AIM, with specialized services for cost-intensive enrollees makes it difficult to negotiate rates with health plans because the risk cannot be spread across a large purchasing pool (i.e., these are pregnant women only, no other enrollees). This in turn, limits the number of health plans willing to participate in the program.**

Governor's Proposed Budget—Shift Eligible Infants to the Healthy Families Program: In order to address funding and caseload issues in AIM, the Administration proposes **to consolidate AIM and enroll *eligible* infants into the Healthy Families Program (HFP) at birth while continuing to provide women with prenatal and postpartum care through AIM. This proposal applies to infants born to women who enroll in AIM on or after July 1, 2004.**

The MRMIB states that by merging AIM in this manner, the state should be able to obtain lower health plan rates for infants via the Healthy Families Program (larger risk pool), as well as achieve other economies of scale through consolidating certain program administration. **Specifically, infants in families *between 200 and 250 percent of poverty* would be funded through the Healthy Families Program using General Fund and federal Title XXI funds (35 percent General Fund to draw a 65 percent federal match).**

AIM infants in families *between 250 and 300 percent of poverty* (above the Healthy Families Program income threshold) would be funded with 100 percent state funds (Proposition 99 Funds).

Although there is no budget year fiscal effect due to the July 1, 2004 implementation date, the Administration assumes net annual savings of $10 million at full implementation. The fiscal affect of this is based on a comparison of the cost of pregnant women and their infants under the current AIM Program versus the infants' cost under the HFP.

Key assumptions include the following:

- **Subscribers would pay a subscriber contribution equal to 1.5 percent** (not the current 2 percent) of the family's annual income for enrollment in AIM **and** then the applicable HFP monthly premium for the **infant,** contingent upon family income level (about $7 to $9 per child per month).
- Infants would be enrolled in the Healthy Families Program at birth.
- Infants 0-12 months with a gross family income **over 250 percent** of poverty would be enrolled in the HFP and funded with Proposition 99 funds.
- **At the infant's first birthday an "annual eligibility review" would be conducted, and the following would occur:**
    - Infants in families with incomes below 133 percent of poverty would be eligible for no-cost Medi-Cal;
    - Infants in families with incomes between 133-250 percent of poverty would remain in the HFP;
    - Infants in families with incomes between 250-300 percent would be in the HFP (using state funds) for one additional year (until age 2); **and**
    - Infants in families with incomes over 300 percent of poverty would be disenrolled.
- At the infant's next annual eligibility review (second birthday), and the following would occur:
    - Infants in families with incomes below 133 percent of poverty would be eligible for no-cost Medi-Cal;
    - Infants in families with incomes between 133-250 percent of poverty would remain in the HFP; and
    - Infants in families with incomes over 250 percent would be disenrolled in the HFP.

It should be noted that this proposal will potentially affect expenditures in the California Children's Services (CCS) Program. This is because children enrolled in the Healthy Families Program are also eligible for CCS services if they meet the medical eligibility criteria. Therefore, MRMIB can potentially obtain better AIM rates because the risk of having high cost, medically involved infants is shifted to the CCS Program where the state and county pick-up the costs. The potential cost shift to the CCS Program is unknown at this time.

Total Proposed AIM Expenditures for 2003-04: A total of $117.5 million ($97.3 million Perinatal Insurance Fund, $7.1 million General Fund, and $13.1 million in Title XXI federal funds), including state support is proposed for AIM. **Of this amount, $116.5 million is for local assistance.** As discussed above, although there is no budget year fiscal effect, the Administration assumes net annual savings of $10.2 million (total funds).

A total of 9,531 women and 138,237 infants are expected to served in AIM in 2003-04.

Subcommittee Request and Questions: The Subcommittee has requested the MRMIB to respond to the following questions:

- **1.** Please **briefly describe the proposal** to shift eligible AIM infants to the HFP, including how the Subscriber payments would change.
- **2.** Specifically, how would the infant be enrolled (i.e., shifted from AIM) to the HFP? Would this be a straightforward, simple process?
- **3.** Please step through each section of the Administration's proposed trailer bill language for this item using the "Hand Out". **(Also, please state what technical fixes are needed to correct the Administration's proposed draft trailer bill, such as the need for emergency regulation authority and a date change.)**
- **4.** How may the California Children's Services Program (CCS) be affected by this proposal?

Budget Issue: Does the Subcommittee want to adopt the AIM consolidation proposal, or modify it?

3. AIM Outreach Funding

Background and Governor's Proposed Budget: The budget proposes **to appropriate $2 million (Proposition 99 Funds)** to conduct a wide variety of outreach activities, including **(1)** presentations and trainings for insurance agents, healthcare plans, schools and government agencies, **(2)** developing and distributing advertisements for television and print media, and **(3)** organizing media events.

Subcommittee Staff Comment: This funding proposal is inconsistent with the Administration's approach in other health care programs where outreach, education, and information assistance has been stripped from the budget. For example, all of the outreach funding for Medi-Cal for children and Healthy Families has been deleted, funding for education activities in TeenSMART has been deleted, information regarding the Newborn Hearing Screening Program has been deleted and there are many other examples.

AIM has been over its estimated caseload every budget year since 1998. **As such, outreach funding could be deleted during a time of fiscal crisis and used to support other health care service programs.**

Budget Issue: Does the Subcommittee want to delete the $2 million (Proposition 99 Funds) from AIM outreach and use it in another programmatic area for health care services?

4. Healthy Families Program Estimate—*ISSUES "A" to "C"*

Background—Overall on the HFP: The Healthy Families Program provides health, dental and vision coverage through managed care arrangements to uninsured children in families with incomes up to 250 percent of the federal poverty level. Families pay a monthly premium and copayments as applicable. The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

Background—Child Health Disability Prevention Gateway for the HFP: Through the Budget Act of 2002, and corresponding trailer bill language, the CHDP Program was modified to create a "gateway". This gateway is used for the CHDP Program (i.e., children not otherwise eligible for Medi-Cal or the HFP), Medi-Cal Program and the HFP. *(The gateway will be discussed further when the Department of Health Services budget is discussed at a later hearing.)*

Under the gateway (to be implemented beginning July 1, 2003) for HFP eligible children, an uninsured, eligible child is "pre-enrolled" in Medi-Cal Fee-For-Service for up to 60-days. During this time, the state is receiving a 65 percent federal Title XXI (S-CHIP) match for services, and the applicant is proceeding with the full HFP (or if applicable, Medi-Cal) application enrollment process.

Governor's Proposed Budget—Overall on the HFP: A total of $814.8 million ($85.3 million General Fund, $220 million Tobacco Settlement Fund and $498.5 million Federal Title XXI

Funds, and $11 million Reimbursements) is proposed for the Healthy Families Program, including state administration. **Of this amount, $809.7 million ($83.6 million General Fund, $220 million Tobacco Settlement Fund, $495.2 million Federal Title XXI Funds and $10.9 million Reimbursements) is for local assistance.**

Further due to the continuing economic downturn, the Governor is proposing to delay implementation of the HFP Parents expansion until July 2006. However, the Legislature does not need to take action regarding this proposal since the HFP Parent expansion can only occur if an appropriation is made for that purpose *(Reference Section 12693.755 of Insurance Code)*. As such, the existing statute regarding the HFP Parent expansion can remain as presently crafted. (The Administration has proposed to change the date (to July 2006) for the bridge from Medi-Cal to Healthy Families; this issue is discuss below, under Issue "B".)

ISSUE "A"— Children's Program Estimate: Caseload and Related Adjustments

Governor's Proposed Budget: The budget proposes total local assistance expenditures of **$809.7 million ($83.6 million General Fund, $220 million Tobacco Settlement Funds** and $495.2 million federal funds) for the children's program. This is about 16 percent more than the current-year. **(It should be noted that it is unclear at this time whether the $220 million in Tobacco Settlement Funds will be available due to the bond securitization.)**

The primary adjustment for the baseline program pertains to caseload increases, with a small shift of some program funding from the Tobacco Settlement Fund to the General Fund.

The budget assumes **a total enrollment of 768,232 children as of June 30, 2004, for an increase of 99,715 children, or about 15 percent, over the revised current year enrollment level.**

This enrollment figure is based **on the sum of four population segments as follows:**

- Children in families **up to 200 percent of poverty:** 556,755 children
- Children in families **between 201 to 250 percent of poverty:** 148,789 children
- Children in families who are **legal immigrants:** 25,573 children
- Child Health Disability Prevention (CHDP) Gateway Access: 37,115 children

The Administration assumes **that net enrollment growth in the budget year will begin to slow as total enrollment reaches the end of the universe of potential eligible children and disenrollments and new enrollments equal out.**

The budget year adjustment also assumes the following key adjustments:

- $88.99 (average cost) for health, dental and vision plan payments per child per month (eligible children aged 1 to 19 years). This reflects a slight increase (was $88.72) over the current year and is based on recent invoiced amounts. **The actual monthly rate paid is based on MRMIB negotiating with the participating plans through a model contract process.** Negotiations are in progress and the May Revision will reflect adjustments.
- $200 (average cost) for health, dental and vision plan payments per infant per month (o to 1 years). This is the same as assumed under the Budget Act of 2002. **The actual monthly rate paid is based on MRMIB negotiating with the participating plans through a model contract process.** Negotiations are in progress and the May Revision will reflect adjustments.
- The Budget Act of 2002 implemented a program change in which the initial premium will cover the first full month of family enrollment. This assumption remains the same for the budget year.
- The administrative vendor payments to EDS reflect final negotiated contract costs (for the period of July 1, 2002 through December 31, 2003) of $5.71 per member per month. MRMIB states that they will be re-procuring a new administrative vendor in the budget year.
- As published in the Federal Register, California's federal matching percentage for the period October 1, 2003 to September 30, 2004 (federal fiscal year) will remain at 65 percent.

Legislative Analyst's Office Comment—Wait for May Revision Estimate: The LAO states that based on their analysis of recent trends, **they believe the Administration's proposed funding level *may be* over budgeted by about $20 million ($8.5 million General Fund).** Specifically, the costs associated with enrollment of children from the CHDP Gateway may be over budgeted by as much as $10 million (total funds) and costs associated with general HFP enrollment may be over budgeted by more than $10 million (total funds).

The LAO notes that since caseload data beyond December 2002 is not yet available, it is unclear whether a caseload enrollment drop in the HFP that occurred in December is actually a downward shift in overall enrollment, or a one-time decrease. They also note that California is experiencing its first "soft economy" since the implementation of the HFP and as such, it is unclear what affect this may have on the rates at which children enroll and disenroll in the program.

Subcommittee Request and Questions: The Subcommittee has requested the MRMIB to respond to the following questions:

- **1.** Please **provide a brief summary** of the request, **including caseload and key assumptions.**

Budget Issue: Does the Subcommittee want to reduce the HFP estimate by $20 million ($8.5 million General Fund) and corresponding federal funds to reflect the LAO comment regarding the likelihood of less estimated caseload, ***or*** wait until the Governor's May Revision when caseload estimate adjustments will be made and more actual data is available?

ISSUE "B"—"Bridge" for Children Moving Between Programs (*See Hand Out)*

Background: Historically, **a one-month "bridge"** has been provided **between the Medi-Cal and HFP programs for children, *and* a two-month bridge has been provided between the HFP and Medi-Cal**. As a families income rises or falls, children can continue to receive health care coverage as they transition to the other program, pending eligibility determination and plan transfer, when applicable.

In the omnibus health trailer bill (AB 430) which accompanied the Budget Act of 2001, statute was changed to provide for a **two-month bridge** between programs as part of the state's HFP Parental Expansion Waiver. However, even though the Waiver was approved by the federal government, **the two-month bridge (from Medi-Cal to the HFP) has never been implemented because funding for the Waiver expansion has not yet been appropriated.**

The two-month bridge (from HFP to Medi-Cal) has been in operation. This **bridge** takes effect when the HFP determines at annual eligibility review that the family's income qualifies the child for no-cost Medi-Cal coverage.

Governor's Proposed Budget (See Hand Out): The Administration is proposing trailer bill language (See page 26, Section 16, of the Hand Out) to change the two-month provision to a one-month provision. **In addition (See page 29, subparagraph "j"), the Administration also proposes to insert an implementation date of October 1, 2006 for the one-month bridge (Medi-Cal to HFP) to change to two months.** The Administration is suggesting this subparagraph language for it would correspond with their concept of when funding may be available for the Waiver and parental expansion.

Subcommittee Staff Recommendation: It is recommended **to modify the Administration's language by modifying subparagraph j (on page 29, the underscored section). The revised suggested language is as follows:**

> (j) The one month of benefits provided in this section shall be increased to two months commencing upon implementation of the waiver as referenced in Section 12693.755.

The one-month reference would be used to replace the two-month reference in the other sections as noted. This would reflect existing funding and practice as the bridge pertains to going from Medi-Cal to the HFP.

In addition, the existing practice of having a two-month bridge in going from the HFP to Medi-Cal will remain. Funds are included in the Governor's budget for this purpose.

Budget Issue: Does the Subcommittee want to adopt the Subcommittee staff recommendation, the Administration's proposed trailer bill language as crafted, **or** another version?

ISSUE "C"—Rural Health Demonstration Projects

Background: The **Rural Health Demonstration Projects, enacted into law in 1997 as part of the original enabling HFP legislation for children**, **are vital projects and have been used to develop and enhance existing health care delivery networks for special populations and to address geographic access barriers.** These projects are an integral component of the Healthy Families Program.

Specifically, the funds have been used **to extend community clinic hours, expand telemedicine applications, provide bilingual specialty health care services, provide mobile medical services and dental services, and rate enhancements to increase HFP provider networks in remote areas. According the Rural Demonstration Project 2002 Fact Book, over 238 projects have been funded with very successful and measurable results.**

The enabling legislation for Rural Health Demonstration Projects contained a sunset clause, as did the Healthy Families Program overall. Specifically, the statute is set to sunset as of July 1, 2003.

Budget Act of 2002: **The Legislature restored a total of $4.8 million ($1 million General Fund, $683,000 Tobacco Settlement Funds and $3.2 million federal funds) for the Rural Demonstration Projects funded under the MRMIB, and the Governor sustained the adjustment.**

Governor's Proposed Budget: The budget proposes to eliminate the Rural Demonstration Projects funds used in the HFP for savings of $4.8 million ($1.7 million General Fund and $3.1 million federal Title XXI funds).

According to the MRMIB, the only reason these projects are being deleted is due to General Fund constraints.

Subcommittee Staff Recommendation: Subcommittee staff recommends to redirect $2 million in Propositions 99 Funds from the Access for Infants and Mothers (AIM) which was to be used for outreach activities (as discussed under item 3, above) and redirect them to the Rural Health Demonstration Projects.

In addition, in order to obtain a federal Title XXI match, **it is also recommended to adopt placeholder trailer bill language which would enable Proposition 99 funds to be used to obtain a federal match specifically for the Rural Demonstration Projects.** If place holder trailer bill language is not adopted, then a federal match cannot be obtained. Due to the structure of Proposition 99, a four-fifths vote of the Legislature is required for passage in order to obtain the federal funds. **Further**, it is recommended **to extend the sunset for the projects for three more years (to January 1, 2007)**.

Budget Issue: Does the **Subcommittee want to adopt (1)** the Administration's budget to eliminate the Rural Demonstration Projects, **(2)** the Subcommittee staff recommendation, ***or*** **(3)** create another option?

5. Medi-Cal and Healthy Families Program Outreach

Budget Act of 2002 and Mid-Year Reduction: **The Budget Act of 2002** significantly reduced the level of funding available for this purpose. Specifically it provided $10.3 million ($3.9 million General Fund and $6.4 million in federal funds). **Generally, the Budget Act of 2002 funds were allocated as follows:**

- Payments to Community-Based Organizations—total of $7.138 million:
  - $6.138 million for Application Assistance Fees; and
  - $1 million for payment processing fees;

- Outreach Support—total of $2.528 million:
  - $1.296 million for Advertising toll-free 888 line;
  - $650,000 for CBO support staff/reporting;
  - $400,000 for application and Health e-app training; and
  - $182,000 for training and presentations.

- Education—total of $650,000
  - $650,000 for administration, research and travel expenditures

The Governor's Mid-Year Reduction, as adopted by the Legislature, reduced $168,000 (General Fund) from the above amount.

Governor's Proposed Budget (See Hand Out—Pages 39 to 42): The budget **proposes to eliminate all of the outreach program, *except* for $1.3 million ($650,000 General Fund). The $1.3 million (total funds) is to be made available for the toll-free telephone lines** which are used to provide program information to various interested parties, including potential enrollees. The proposed trailer bill language makes outreach activities permissive, not mandatory and contingent upon appropriation in the annual Budget Act.

Subcommittee Staff Recommendation: Due to General Fund fiscal constraints, it is recommended to adopt the Administration's proposal, including the proposed trailer bill language.

Subcommittee Request: The Subcommittee **has requested the DHS and MRMIB to briefly describe their proposal *and* to step through the proposed trailer bill language (pages 39 to 42).**

Budget Issue: Does the Subcommittee want to concur with the Administration's proposal to delete all funding except for the $1.3 million and to adopt the proposed trailer bill language, ***or*** to modify the proposal?

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